# Screening for Intimate Partner Violence During Pregnancy

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Intimate partner violence (IPV) is defined as an actual or threatened abuse by an intimate partner that may be physical, sexual, psychological, or emotional in nature. Each year approximately 1.5 million women in the United States report some form of sexual or physical assault by an intimate partner; it is estimated that approximately 324,000 women are pregnant when violence occurs. Pregnancy may present a unique opportunity to identify and screen for patients experiencing IPV. This article provides health care practitioners and clinicians with the most current valid assessment and screening tools for evaluating pregnant women for IPV.

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**KEY WORDS**

Intimate partner violence • Fetal risk • Screening and detection

This article provides health care practitioners and clinicians with the most current valid assessment and screening tools for evaluating pregnant women for intimate partner violence (IPV) in a health care setting. IPV is defined as an actual or threatened abuse by an intimate partner that may be physical, sexual, psychological, or emotional in nature.[1] Intimate partners can be both current and former marital or nonmarital partners, including a spouse, girlfriend or boyfriend, or dating partner of the same or opposite sex. It is important to note that IPV can also encompass a wide range of controlling or threatening behaviors not limited to physical or sexual abuse and battery, such as economic control, manipulation of children, and isolating the women from friends and family.

## IPV and Pregnancy

Each year approximately 1.5 million women in the United States report some form of rape or physical assault by an intimate partner.[2] It is estimated that approximately 324,000 women are pregnant when violence occurs; however, this number is grossly underestimated.[3] In addition, approximately 8.6% of women (approximately 10.3 million women in the United States), have reported an intimate partner who refused to use a condom or tried to get them pregnant when they did not want to become pregnant.[4] This form of forced and unwanted control of reproductive and sexual health also represents a form of IPV that may be overlooked. Studies have investigated possible associations between IPV and unintended pregnancy, delayed prenatal care, and behavioral risk factors such as smoking, and alcohol and drug abuse, which can all translate to adverse fetal outcomes.

*Pregnancy may present a unique opportunity to identify and screen for patients experiencing IPV.*

Pregnancy may present a unique opportunity to identify and screen for patients experiencing IPV. It is a longitudinal process involving repeated contact with health care providers, offering the unique opportunity to develop trust between the patient and members of the health care team. In addition, victims of IPV may be motivated by the desire to become good parents and protect their unborn children from possible abuse by an intimate partner. This can serve as a powerful motivator to confide in a health care provider and seek counsel and assistance.

## Broad Range of IPV

IPV can encompass a wide variety of violent and controlling behaviors and is not limited to physical and/or sexual abuse. Physical abuse includes any form of direct, intentional use of force that is unwanted and may have potential for causing injury, harm, or death to both the pregnant mother and her fetus. This may include slapping, pushing, shaking, biting, scratching, choking, burning, hitting, or using a knife, gun, or other weapon. Sexual violence involves any nonconsensual or unwanted sexual contact, often accompanied by physical force or threat. It can include completed or attempted penetration of the vagina, anus, oral cavity, or other forms of sexual contact, such as unwanted touching or fondling. Psychological or emotional violence involves nonphysical acts or behaviors that can negatively affect the victim. These are particularly important as they are often neglected by the patient, not addressed by the provider, or sometimes not considered as forms of violence or abuse. Examples include humiliation, name-calling or cursing, use of profanity, deliberate embarrassment, economic/financial manipulation and control, isolation from friends and family, withholding information and resources, and controlling movement and activities. Psychological aggression includes all behaviors intended to monitor or control or threaten an intimate partner. Control of reproductive and sexual health is another form of IPV, which includes refusal by an intimate partner to use a condom and forcing a woman to become pregnant when she does not want to. It is also important to recognize that the unifying and underlying components to all these forms of violence are coercive control and intimidation. Threats and intimidation are often alternated with acts of compassion and kindness, which can steer the victim into a cycle of forgiveness that can make it difficult to report the violence, seek help, and, ultimately, gain autonomy and safety. This cycle of violence consists of three phases: (1) tension building, (2) acute battering followed by the "honeymoon stage," and (3) repetition of the cycle, all of which are usually centered around the patient's denial of the situation (Figure 1).

## Screening in the Health Care Setting

In the 2012 *New England Journal of Medicine* article, "Intimate partner violence—what physicians can do," the authors report that under the new guidelines of the Patient Protection and Affordable Care Act, all women of childbearing age qualify for free insurance coverage of IPV screening and counseling as part of eight essential preventive health services for women with no additional cost to the patient.[5] Recent studies of the screening practices of physicians, including obstetrician-gynecologists, suggest that most clinicians only conduct screening for violence when obvious warning signs are observed. We now understand that

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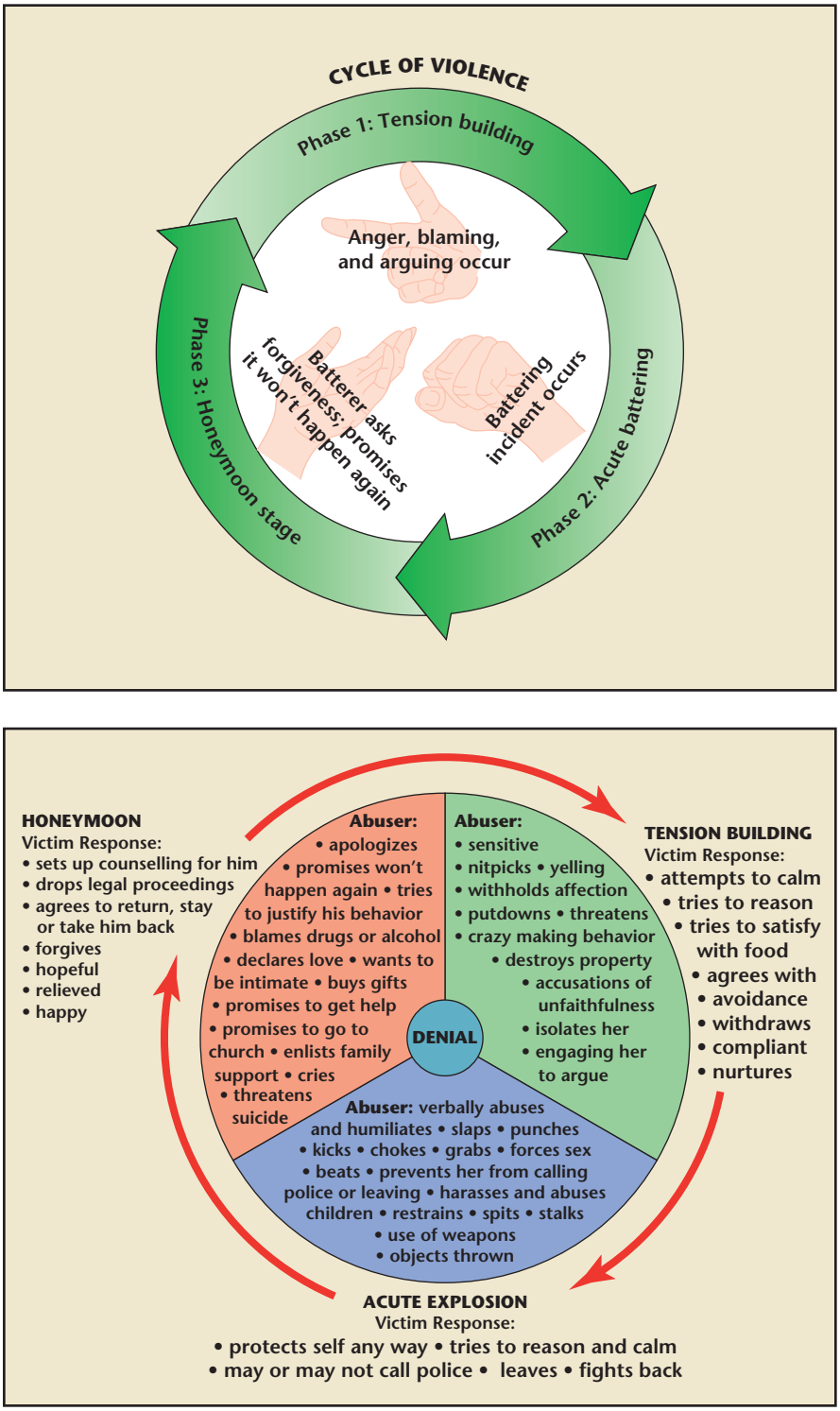


**Figure 1.** Cycle of violence.

IPV can also exist in the absence of warning signs in the patient's history, behavior, or physical examination findings. Women may not present with symptoms or findings and may actively attempt to conceal what they experience at home. Practitioners should be tuned to other more discrete clues that may indicate IPV. For these reasons, it becomes essential to screen every patient routinely. The American College of Obstetrics and Gynecology encourages screening of all women at routine and regular intervals for IPV.

Based on recommendations by the US Centers for Disease Control and Prevention and the ACOG Committee Opinion on intimate partner violence,[6] we have adapted a brief checklist for practitioners to utilize in the health care setting in order to identify signs of IPV (Figure 2). This checklist includes specific items for clinicians to explore in patients' medical history and their behavior during the office visit.

## Fetal Risks of IPV

Though there is no consistent or conclusive research to indicate the direct impact of IPV on fetal health, it is known that spontaneous abortion, fetal injury, and fetal death are associated with trauma to the mother. IPV may cause maternal stress and provoke substance abuse, which can cause indirect adverse fetal health effects including low birth weight, intrauterine growth restriction, and fetal alcohol syndrome. Recent evidence from the National Institutes of Health analyzing data of more than 5 million pregnant women in California over a 10-year period shows that pregnant women who were assaulted by an intimate partner were at an increased risk of giving birth to infants of reduced weight.[7] The study found that "infants born to women who were hospitalized for injuries received from an assault during their pregnancies weighed, on average, 163 grams or one-third pound less than did infants born to women who were not hospitalized . . . assaults in the first trimester were associated with the largest decrease in birth weight."[7] Women in controlling and abusive relationships may also have difficulty in fulfilling prenatal care

| **Step 1: Review Medical History for Warning Signs of Intimate Partner Violence** |
|---|
| • Previous medical visits for injuries<br>• History of abuse or assault<br>• Repeated visits<br>• Chronic pelvic pain, headaches, vaginitis, irritable bowel syndrome<br>• History of depression, substance use, suicide attempts, anxiety |
| **Step 2: Review Medical History for Pregnancy-related Factors** |
| • Unintended pregnancy<br>• Unhappiness about being pregnant<br>• Young maternal age<br>• Single marital status<br>• Higher parity<br>• Late entry into prenatal care/missed appointments<br>• Substance use or abuse (tobacco, alcohol, drugs) |
| **Step 3: Observe Woman's Behavior** |
| • Flat affect<br>• Fright, depression, anxiety<br>• Post-traumatic stress disorder symptoms<br>  ○ Dissociation, psychic numbing, startle responses<br>• Overcompliance<br>• Excessive distrust |
| **Step 4: Observe Partner's Behavior** |
| • Being overly solicitous<br>• Answering questions for the patient<br>• Being hostile or demanding<br>• Never leaving the patient's side<br>• Monitoring the woman's responses to questions |
| **Step 5: Ask Directly** |
| • Ask questions in private apart from male partner, family, or friends<br>• Explain issues of confidentiality<br>• Be aware of mandatory reporting laws in your state and inform the woman of them<br>• Face-to-face talk more effective than written questionnaires<br>• Ask caring and empathetic questions<br>• Be prepared to hear your patient's answer |

**Figure 2.** Identifying intimate partner violence in the healthcare setting. Adapted from Centers for Disease Control and Prevention.[12]

responsibilities (eg, attending prenatal visits, maintaining adequate nutrition and supplementation, and receiving treatment for sexually transmitted infections or substance abuse recovery).

## Screening Tools for IPV

### *RADAR Tool*

RADAR was an acronym-mnemonic developed by the Massachusetts Medical Society in 1992 that helps summarize key action steps that physicians should take in recognizing and treating patients affected by IPV (Figure 3). The steps of RADAR include the following: (1) **Routinely** screen adult patients, (2) **Ask** direct questions, (3) **Document** your findings, (4) **Assess** patient safety, and (5) **Review** options and referrals. The RADAR method has been a very popular screening prompt that has been adopted nationally across numerous medical, community-based, mental health, and legal organizations. Its goal is to reinforce care, support, and trust in the patient-provider relationship, ensure appropriate follow-up care in subsequent patient visits, and refine ongoing physician education and expertise.

### *HITS Tool*

Another screening tool called HITS is increasingly used in clinical practice to assess IPV (Figure 4). During the HITS assessment, a provider asks a patient the following: How often does your partner physically **Hurt** you, **Insult** or talk down to you, **Threaten** you with harm, and **Scream** or curse at you? Each category is graded on a scale of 1 (never) to 5 (frequently) and a sum of all the categories is generated. A total score of $>$ 10 is suggestive of IPV.

### *AAS Tool*

Perhaps one of the most widely used IPV screening tools in the pregnant population is the Abuse Assessment Screen (AAS) tool (Figure 5).[8] This is a short, five-question screen that involves the following open-ended questions:

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Since I saw you last have you been hit, slapped, kicked, or otherwise physically hurt by someone?

**R**emember to ask routinely about IPV as a matter of routine patient care.

**A**sk directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview your patient in private at all times.

**D**ocument findings related to suspected intimate partner violence in the patient's chart.

**A**ssess your patient's safety. Is it safe to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

**R**eview options with your patient. Know about the types of referral resources in your community (eg, shelters, support groups, legal advocates).

**Figure 3.** RADAR screening tool developed by the Massachusetts Medical Society. Adapted from Basile KC, et al.[1]

If YES, by whom? Number of times? Nature of injury?

3. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, by whom? Number of times? Nature of injury?
4. Within the past year has anyone made you do something sexual that you did not want to do? If YES, then who?
5. Are you afraid of your partner or anyone else?

In one population-based study of 691 pregnant women, the AAS asked at the first prenatal visit was sensitive and specific to abuse status when evaluated against nationally tested instruments.[9] Abuse was recurrent, with 60% of women reporting two or more episodes; abused women were twice as likely to begin prenatal care during the third trimester than their not-abused counterparts. In another study comparing 143 AAS-screened pregnant women with 191 non–AAS-screened pregnant women, the five-question AAS screen improved detection rates of battering both before and during pregnancy more than did a standard patient interview.[10] Thus, structured screens of IPV can better enable clinicians to detect IPV early and allow the opportunity for intervention.

For any of these three screening tools (RADAR, HITS, AAS) to be most effective in the clinical setting, they should be used longitudinally during visits at each trimester and also at the postpartum examination. IPV can occur at any time before, during, or after pregnancy so consistent use of any screening method will result in the highest rate of detection and prevention.

## Next Steps After IPV Screening and Detection

Sometimes even after taking the appropriate steps for screening and patient education, your patient may still choose not to tell you her circumstances or may respond negatively to your questions about IPV. In this scenario, it is critical to still consistently document your findings, express your willingness to discuss her questions or concerns about IPV, and let her know that you are always available as a resource. Some women believe that IPV has mandatory reporting laws, but there are only a few states in which this is true, and being familiar with these state laws is important. There are other circumstances in which a patient may respond affirmatively but be unwilling to discuss or share any further details. In this situation, it is most beneficial to express support, tell her that the abuse is

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**Figure 4.** HITS Screening Assessment for Intimate Partner Violence

**The HITS Screening Tool for Domestic Violence***

| How Often Does Your Partner | Never | Rarely | Sometimes | Fairly Often | Frequently |
|---|---|---|---|---|---|
| Physically hurt you | 1 | 2 | 3 | 4 | 5 |
| Insult or talk down to you | 1 | 2 | 3 | 4 | 5 |
| Threaten you with harm | 1 | 2 | 3 | 4 | 5 |
| Scream or curse at you | 1 | 2 | 3 | 4 | 5 |

*A total score of more than 10 is suggestive of intimate partner violence. This information, called R3, is available as a free Android or iPhone application. Data from Sherin KM et al.[13]

**Abuse Assessment Screen (Circle YES or NO for each question)**

1. Have you ever been emotionally or physically abused by your partner or someone important to you? ..... YES NO
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? ..... YES NO

   If YES, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total No. of times _____
3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

   If YES, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total No. of times _____

   Mark the area of injury on a body map

   Score each incident according to the following scale:

   1 = Threats of abuse, including use of a weapon
   2 = Slapping, pushing; no injuries and/or lasting pain
   3 = Punching, kicking, bruises, cuts, and/or continuing pain
   4 = Beaten up, severe contusions, burns, broken bones
   5 = Head, internal, and/or permanent injury
   6 = Use of weapon, wound from weapon

   (If any of the descriptions for the higher number apply, use the higher number)
4. Within the last year, has anyone forced you to have sexual activities? ..... YES NO

   If YES, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total No. of times _____
5. Are you afraid of your partner or anyone you listed above? ..... YES NO

**Figure 5.** Abuse Assessment Screen for intimate partner violence. Reprinted with permission from Soeken KL et al.[8]

not her fault, that no one deserves that type of treatment. You can use the creator wheel to help her visually and schematically compare healthy, equality-centered relationship behaviors to controlling, violent, and unhealthy relationship behaviors and show her that she deserves a more equal partnership (Figure 6). Ask her how you can best support her. If your comments are powerful, encouraging, and supportive, they may stimulate dialogue and your patient to consider changing her situation. Remember to always be your patient's advocate and to stay on her side.

In the circumstance that a patient reveals and describes specific examples of IPV, it becomes necessary to document findings in the patient's charts in her own words. You may choose to use a body map, provide further screening questionnaires, or include patient photographs with consent. At this point, it is critical to perform a safety assessment and/or develop a safety plan with your patient. You may choose to connect your patient to a nurse, social worker, advocate, community resource, or health care worker that is specifically trained in violence prevention. Key questions to ask include whether your patient and her children are in immediate danger, whether there are weapons at home, if the violence has recently escalated, if substance abuse is involved, and if there is an alternate environment where she can ensure her safety and protection.

## Conclusions

IPV is a significant public health problem associated with adverse health consequences for victims. Pregnant women represent an important cohort of patients that should be routinely screened for IPV to ensure positive health for

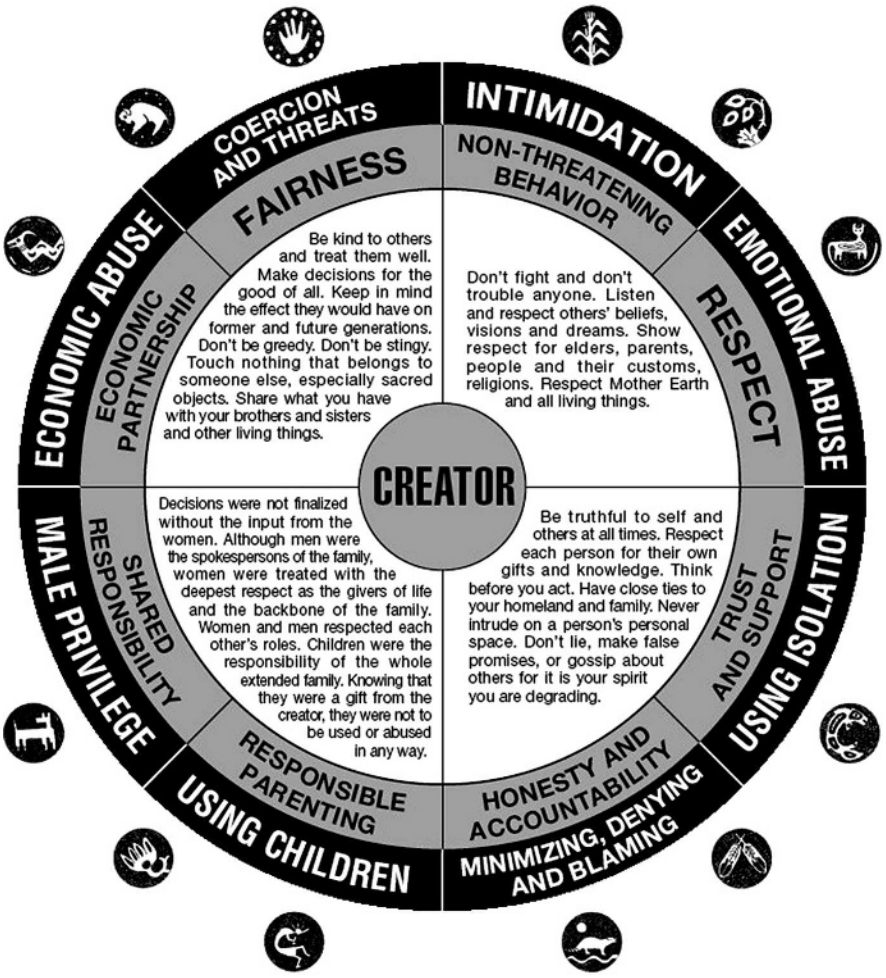


**Figure 6.** Creator wheel: a tool for comparing violence to equality.

both mother and fetus. The obstetrician-gynecologist can use the longitudinal course of the pregnancy to establish sufficient patient trust allowing for disclosure of potential IPV. Structured screening tools may provide better detection than the standard patient interview. By developing familiarity with key resources, state IPV reporting policies, screening methods, and both direct and indirect signs and symptoms of IPV, obstetrician-gynecologists can play a critical role in early prevention and reduction of IPV in their patients.■

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## MAIN POINTS

- Intimate partner violence (IPV) is defined as an actual or threatened abuse by an intimate partner that may be physical, sexual, psychological, or emotional in nature. It is important to note that IPV can also encompass a wide range of controlling or threatening behaviors not limited to physical or sexual abuse and battery, such as economic control, manipulation of the children, and isolating women from friends and family.
- Pregnancy may present a unique opportunity to identify and screen for patients experiencing IPV. It is a longitudinal process involving repeated contact with health care providers, offering the unique opportunity to develop trust between the patient and members of the health care team.
- Though there is no consistent or conclusive research to indicate the direct impact of IPV on fetal health, it is known that spontaneous abortion, fetal injury, and fetal death are associated with trauma to the mother. IPV may cause maternal stress and provoke substance abuse, which can cause indirect adverse fetal health effects including low birth weight, intrauterine growth restriction, and fetal alcohol syndrome.
- For any of the three IPV screening tools (RADAR, HITS, and AAS) to be most effective in the clinical setting, they should be used longitudinally during obstetric visits (at the first prenatal visit, at least once per trimester, and at the postpartum checkups).
- By developing familiarity with key resources, state IPV reporting policies, screening methods, and both direct and indirect signs and symptoms of IPV, obstetrician-gynecologists can play a critical role in early prevention and reduction of IPV in their patients.

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